DELAY IN DIAGNOSIS OF BREAST CANCER

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In this issue, we introduce a column featuring comments from a senior consultant to fellow clinicians on a medicolegal topic.

Breast cancer is the most common cancer in women in North America, and the cancer most feared by women. This year, approximately 180,000 new cases of breast cancer will occur, and about 50,000 women will die from the disease. The incidence has risen in the past few decades. We have no known effective means of preventing this cancer (short of performing prophylactic mastectomy), so we must rely on the earliest possible diagnosis to have the best outcome.

Breast cancer is one of the cancers where an early diagnosis can make a definite difference. Both prospective and retrospective studies have repeatedly shown a more favorable outcome with smaller primary lesions and fewer involved axillary lymph nodes. Of course, there are instances of biologically aggressive cancers that have an adverse prognosis no matter how small the primary tumor, but, in general, there is a direct correlation between tumor size, lymph node status, and curability of this cancer. The attempt to find smaller cancers and treat them earlier is the basis for our concerted effort to encourage women to undergo screening mammograms and physical examinations.

In my experience, both as an oncologist and as an occasional consultant on cases of alleged medical negligence, the failure of physicians to diagnose breast cancer in a timely fashion is the most common source of malpractice suits in oncology and the second most common source in medicine. In fact, at least one national malpractice insurer has a designated task force to deal solely with cases related to a delay in diagnosis of breast cancer.

Patients often perceive that any delay, even of several weeks, in diagnosis has a negative effect on their ability to be cured. If there is a delay of some months, then patients can become so upset that they seek legal redress. Given available data, it seems that physicians too often err in making a diagnosis of breast cancer and that these errors too often result in lawsuits.

The bases of these diagnostic errors are several. One is the misconception that women in their twenties and thirties only rarely suffer breast cancer, and a breast mass in this age group is therefore unlikely to be cancer. Contrary to this impression, about 10 percent of breast cancer occurs in women under age 35. Another common mistake is to label a breast lesion (be it a true mass, a "ridge," a "fullness," or an "irregularity") as "fibrocystic disease" based upon palpation alone. Fibrocystic disease cannot be detected by palpation. Some argue that this condition is mislabeled and not even a disease.

A final, too common, mistake is to use a mammogram as a diagnostic test. A mammogram is a screening tool and not a diagnostic test. When the physician is presented with a breast complaint, mammograms can be helpful in assessing the breast after careful palpation. A lesion may be seen that is highly suspicious for malignancy. It may show an additional lesion in the same or opposite breast that also warrants

investigation. However, a mammogram which is "negative for malignancy" should never be used as the basis for a lack of further concern or study. Mammograms, depending on the quality of the films and experience of the interpreter, will miss definite cancers 15-20 percent of the time. This false negative rate is higher in premenopausal women who often have dense breast tissue that may obscure cancers on x-ray.

When the physician is presented with a breast complaint, the immediate thought must be, is this due to cancer? Breast cancer is common enough to be always a consideration when a new breast symptom occurs. Cancer is also the worst possible etiology for the new symptom.

The physician should then approach the patient with the idea in mind that a biopsy, or at least a fine-needle aspiration, is going to be ultimately necessary to establish the diagnosis. A mammogram is done to gain further information, and a sonogram can sometimes provide aid in differentiating a cyst from a solid lesion. A fine needle aspiration is the next step and involves minor morbidity. The physical examination, the mammogram, and fine needle aspiration taken together are highly accurate when each produces the same result. However, any solid mass should be biopsied to provide maximum assurance that the lesion is benign. More biopsies are benign than malignant, but no clinical or radiologic assessment is as accurate as a biopsy. When there is any doubt, biopsy is indicated. If a biopsy is to be done only after a period of observation, this interval should be no longer than four to six weeks.

My oncology practice and my consultant experience lead me to make the following observation. Keep in mind the frequency of breast cancer, its generally higher curability with small, node-negative lesions, and the fact that only a biopsy can totally rule out cancer. Do not make the mistake of using the mammogram as a diagnostic test, and do not contribute to a delay in the diagnosis of this disease.